

Do you want someone to file an appeal, grievance, or organization determination on your behalf?



If yes, fill out the Appointment of Representative form on the next page.

What is the Appointment of Representative form?

It's a form that gives permission for someone to take certain actions on your behalf related to your Medicare plan and benefits — like filing an appeal, grievance, or organization determination.

Do I need to fill it out?

It depends. You need to fill out this form if **ALL** of the following are true:

You plan to file an appeal, grievance, or organization determination

You want someone you trust (like a friend or family member) to file on your behalf or be able to follow up with Devoted about your request

You do **not** have a durable general power of attorney set up with the person who's helping you

Does this form also give permission to share my protected health information (PHI)?

The person you name will automatically have limited permission to access PHI related to actions they take on your behalf. If you'd also like them to have full permission to access your PHI, you'll need to fill out a separate form. See the back of this page for details.

What if I have questions?

Text us at **866-85** or call **1-800-338-6833 (TTY 711)**. We're here 8am to 8pm, Monday to Friday (October 1 to March 31, 8am to 8pm, 7 days a week).

Where do I send the form?

Once you and your representative have completed and signed the form, send it to us at:

Mail

Devoted Health – Enrollment
PO Box 211037
Eagan, MN 55121

Fax

1-877-264-3859



Your care team is more than just your doctors.

If you have family or friends who help with your care, they're part of your team too. It's important for us to have the right forms on file so they can support you. Here's how to figure out which forms will give the right permissions:

Type of form		What it includes	How to set it up
Protected Health Information (PHI) Sharing		<ul style="list-style-type: none"> Receive your PHI (get information from Devoted about your plan benefits and your care) 	Visit my.devoted.com/share , text SHARE to 866-85 , or call us to get a paper form
THIS FORM →	Appointment of Representative (AOR)	<ul style="list-style-type: none"> File appeals, grievances, and organization determinations Receive <u>limited</u> PHI (only related to appeals, grievances, organization determinations) 	Use the form on the next page
ACTIVE Medical Power of Attorney*		<ul style="list-style-type: none"> Receive your PHI Book medical visits for you Change your PCP Consent to healthcare on your behalf 	Consult a lawyer or get a form from your state, your doctor, or a trusted group like prepareforyourcare.org
Durable General Power of Attorney**		<ul style="list-style-type: none"> Receive your PHI File appeals, grievances, and organization determinations Book medical visits for you Change your PCP Change your address or health plan enrollment Give permission for others to receive your PHI 	Consult a lawyer or get a form from your state

* Many Medical Power of Attorney forms (also called *Healthcare Surrogate* or *Healthcare Proxy*) only become active once the person is unable to make their own decisions.

** Depending how it's written, a Durable General Power of Attorney may give a wide range of permissions to act on your behalf in financial and legal matters, or more limited permissions.

Have a completed Power of Attorney form?

Mail or fax it to us using the instructions on page 1.

To file a complaint with Devoted Health, call us at 1-800-338-6833 (TTY 711). To file a complaint with Medicare, call 1-800-MEDICARE (TTY 1-877-486-2048), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include their name when you file your complaint. This information is not legal advice. Using or relying on this information does not create an attorney-client relationship. Devoted Health is not liable for any actions you take or don't take based on this information.

Need Help? Call **1-800-338-6833** (TTY 711) or text us at **866-85**

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Appointment of Representative

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information, and receive all communication about your action. This person may see your personal medical information. **All fields in Sections 1 and 2 are required unless marked optional.**

Section 1: Information about the person appointing the representative

This section must be completed by the patient, provider or other person appointing a representative.

Name	Medicare Number or National Provider Identifier	
Mailing address	Phone number (with area code) (<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
City	State <input type="text"/> <input type="text"/>	ZIP code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email (optional)	Fax (optional) (<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Signature	Date signed (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Section 2: Information about the representative

This section must be completed by the representative.

Representative name		
Professional status or relationship to the person in Section 1 (attorney, relative, etc.)		
Mailing address	Phone number (with area code) (<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
City	State <input type="text"/> <input type="text"/>	ZIP code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email (optional)	Fax (optional) (<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
By signing below, you agree to act as a representative and certify that you haven't been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) or otherwise disqualified from acting as a representative. Any fee to be charged for acting as a representative may be subject to review and approval by the Secretary. If you're charging a fee, go to instructions on page 2.		
Signature	Date signed (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Representative must complete the sections below, if applicable (go to instructions on page 2)

Section 3: Waiver of fee for representation

Providers and suppliers who furnished the items or services at issue can't charge a fee for representation and must sign below to waive their fee. Representatives who choose to waive their fee for representation must also sign below.

I waive my right to charge and collect a fee for representing the person in Section 1 before the Secretary of HHS.

Signature	Date signed (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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Section 4: Waiver of payment for items or services at issue

If you're a provider or supplier and you furnished items or services to the patient you're representing, if the appeal involves a question of whether you or the patient didn't know, or couldn't reasonably be expected to know, that Medicare wouldn't cover the items or services.

I waive my right to collect payment from the patient for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is made.

Signature	Date signed (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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Instructions and Regulation Requirements

Instructions

All fields in Sections 1 and 2 are required unless marked “optional.” If the person or entity appointing a representative doesn’t have a Medicare number or National Provider Identifier, fill in “not applicable.” Go to the regulation at 42 CFR 405.910: [ECFR.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910)

Waiver of Fee for Representation Section 3 is required when a representative is required, or has agreed, to waive or not charge a fee for their representation. Waiver of Payment for Items or Services at Issue Section 4 is required if a provider or supplier who furnished items or services to the patient represents the patient and liability (knowledge of non-coverage) under §1879(a)(2) of the Act is at issue in the appeal. Go to 42 CFR 405.910(f).

An appointment of a representative is considered valid for one year from the date this form is signed by both the person appointing a representative and the appointed representative. A completed form can be used for other appeals or actions during the one-year period it’s valid. Unless revoked, the representation is valid for the duration of the claim, appeal, grievance, or request for which it was filed.

Charging fees for representing patients before the Secretary of HHS

An attorney, or other representative for a patient, who wants to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court), is required to have the fee approved in accordance with 42 CFR 405.910(f).

The representative should complete the form OMHA-118, “Petition to Obtain Approval of a Fee for Representing a Beneficiary” and file it with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Fee approval is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed representative, and the court approved the fee; (3) the fee is for representing a patient in a proceeding in federal district court; or (4) the fee is for representing a patient in a redetermination or reconsideration. Representatives are permitted to waive their fee if they choose. Get form OMHA-118 here: [HHS.gov/sites/default/files/OMHA-118.pdf](https://www.hhs.gov/sites/default/files/OMHA-118.pdf)

A provider or supplier who furnished the items or services to a Medicare patient that are the subject of the appeal may represent that patient in an appeal, but the provider or supplier may not charge the beneficiary any fee associated with the representation. (42 CFR 405.910(f)(3).)

Approval of fee

The fee approval requirement ensures that a representative is paid fairly for their services and that patient fees are reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required, the amount of time spent on the case, the results achieved, the level of administrative review needed, and the amount of the fee requested.

Conflict of interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain current and former officers and employees of the United States to render certain services in matters affecting the government or to aid or assist in prosecuting claims against the United States. Individuals with a conflict of interest are excluded from serving as representatives of patients before HHS.

Where to send this form

Send this form to the same location you send your claim, appeal, grievance, or request.

Get help & more information

For questions about this form, contact your Medicare plan or call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you’ve been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE for more information.

Paperwork Reduction Act: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
